Revised September 9, 2005

Summary of the Meeting of the CON Task Force

August 25, 2005

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Task Force Members Present

Commissioner Robert E. Nicolay, CPA, Chairman
Albert L. Blumberg, M.D., F.A.C.R.
Lynn Bonde
Patricia M.C. Brown, Esquire
Annice Cody
William L. Chester, M.D.
Hal Cohen, Ph.D.
Carlessia A. Hussein, DrPH
Adam Kane, Esquire
Henry Meilman, M.D.
Lawrence Pinkner, M.D.
Frank Pommett, Jr.
Barry F. Rosen, Esquire
Joel Suldan, Esquire
Christine M. Stefanides, RN, CHE
Jack Tranter, Esquire
Douglas H. Wilson, Ph.D.
Elizabeth Weglein

Task Force Members Absent

Commissioner Larry Ginsburg
Alan Bedrick, M.D.
Natalie Holland
Commissioner Robert E. Moffit, Ph.D.
Michelle Mahan
Anil K. Narang, D.O.

Members of the Public Present

Clarence Brewton, MedStar Health
Jack Eller, Ober, Kaler
Denise Matricciani, MHA: Association of Maryland Hospitals & Health Systems
Frank Monius, MHA: Association of Maryland Hospitals & Health Systems
Vanessa Purnell, MedStar Health
Laura Resh, Carroll Hospital Center
Olivia Stewart, Jack Neil & Associates
Gail Thompson, Kaiser Permanente
Pegeen Townsend, MHA: Association of Maryland Hospitals & Health Systems
Greg Vasas, CareFirst BlueCross BlueShield

1. Call to Order

Chairman Robert E. Nicolay called the meeting to order at 1:12 p.m. and welcomed Task Force members and the public.

2. Approval of the Previous Minutes (August 11, 2005)

Chairman Nicolay noted that the Task Force members had received copies of the minutes of the August 11th meeting and asked for any comments, changes, or corrections. Patricia M.C. Brown, Esquire, requested a revision to reflect that it was her opinion that some of the proposed changes would require a regulatory change, rather than a change to the Commission's statute. Task Force member Albert L. Blumberg, M.D., F.A.C.R., made a motion to approve the minutes, as revised, which was seconded and approved by the members present with the exception of Hal Cohen, Ph.D. and Jack Tranter, Esq., who abstained.

3. Review and Discussion of the Public Comments Received on the CON Program

- **Recap of August 11, 2005 Meeting**

1. Task Force Review and Discussion of CON Issues

- Recap and Follow-up: August 25, 2005 Meeting
  - Follow-up Items
- Review of Draft CON Task Force Report (9/8/05)
- CON Review Process
  - Streamlined ("Fast Track") CON Review Process
  - CON Application Form and Filing (Electronic Filings/Website Access)
  - Require Site Visits and Local Hearings on All Major CON Projects
  - Eliminate Scheduled CON Reviews
  - Other
- State Health Plan
  - Emergency Department/Outpatient Services
  - Freestanding Birthing Centers

2. Other Business
   - Burn Care Services

3. Adjournment

Chairman Nicolay presented a recap of the August 11th meeting. He noted that the Task Force received many comments regarding the Commission's need to revise the State Health Plan for Facilities and Services (State Health Plan, or SHP); however, time would not permit the Task Force to consider all of the State Health Plan issues.

- **State Health Plan Issues: State Health Plan Update**

Chairman Nicolay suggested that the Task Force members consider several options, with a goal of reaching consensus, on the best way to address the subject.

Pamela Barclay, Deputy Director of Health Resources, presented the following options for updating the State Health Plan:

- Defer review of all new CON applications until the State Health Plan is fully revised and updated;

- Continue the review of CON applications and focus on updating only those portions of State Health Plan chapters needed to review the types of CON applications that are likely to be filed over the next 12 to 24 months; or

- Target 1-2 State Health Plan chapters for a full revision annually so that in a five-year cycle, the Commission will have addressed all of the chapters.

Dr. Cohen noted that his written comments to the Task Force included a suggestion for adding a chapter to the SHP on emergency department services—one of the most rapidly growing hospital services for which Certificate of Need (CON) applications are filed, in his opinion. He emphasized that no standards address these services in the SHP. Chairman Nicolay assured the Task Force members that emergency department services, in addition to several other proposed changes, would be considered at a future meeting.

Dr. Blumberg noted that, as he had previously proposed, reducing the requirements for CON would make revision of the SHP less acute. His interpretation of the cause of delays in the update of the SHP was that "finite staff resources" had been diverted from monitoring the SHP to analyzing CON applications. In his view, the second and third options presented, in light of the Commission's budgetary and staffing constraints, were not achievable. Ms. Barclay suggested that Task Force members should assume that that the Commission would not be given major additional resources to devote to its work regarding CON and the SHP.

Dr. Blumberg asked if the staff believes that it has sufficient staff to achieve option two or option three. Ms. Barclay replied that option two described the current process. Targeted updates of the SHP, driven predominantly by the CON work, such as the recent updates of the acute care bed need projection and the Obstetrics Chapter, have been promulgated by the Commission. She noted that staff shares the concerns expressed in the comments.

Jack Tranter, Esquire, opined that the declaration of a moratorium described in option one would be an unlawful act. Option two would be the best and most appropriate approach, in his opinion. He expressed disappointment at the suggested deferral of consideration of some of the issues

in the acute inpatient services chapter of the SHP because it is presently used most often. Mr. Tranter noted that the Maryland Hospital Association (MHA) identified many standards in the acute inpatient services chapter that were "not useful," such as requirements in CON applications for utilization data, the travel time standard, information regarding charges, and charity care policies, among others. He suggested that the Task Force deliberate those targeted comments as it considers SHP issues. Dr. Cohen agreed with Mr. Tranter's suggestion, and observed that the record of many of the CON applications, in his view, contains numerous irrelevancies. In response to a request for clarification from Carlessia A. Hussein, DrPH, Mr. Tranter stated that the Commission could adopt and change the CON review criteria.

Dr. Hussein suggested that the staff assess the extent to which the review criteria are necessary in analyzing applications and making recommendations to the Commission. Ms. Barclay noted that staff agreed that some of the SHP standards should be revisited for appropriateness in the applications being currently reviewed; however, other comments received by the Task Force related to how the SHP is structured and higher order issues, since the SHP is the guiding blueprint for the Commission's work in these areas. The staff could do a "targeted" adjustment, as it has been doing, or it could revisit some of the larger policy issues in a full re-write of the SHP.

Mr. Tranter suggested that the Task Force consider and recommend adoption of the twenty-four specific "housekeeping" recommendations made by the MHA work group to the Commission.
Joel Suldan, Esquire, proposed that the Commission adopt a different review process that includes a requirement for CON applicants' certifying that they meet the standards on the "housekeeping" list. Ms. Barclay pointed out that the Commission is required to make a finding for all review criteria set forth in the CON regulations.

Adam Kane, Esquire, proposed that subcommittees be created for deliberation and recommendations on these State Health Plan issues. William L. Chester, M.D. opposed Mr. Kane's suggestion, observing that the entire Task Force's breadth of expertise, as shared during deliberations, was a valuable component in forming recommendations; however, he would favor disposition of the housekeeping issues by a subgroup. Christine M. Stefanides, RN, CHE agreed that the housekeeping issues must be addressed. In her view, the Commission is burdened with monitoring regulations that do not pertain to CON applications. The expertise of staff needs to be focused on the CON issues and not addressing "other regulatory monitoring that seems to be cluttering up the application." Barry F. Rosen, Esquire, surmised that one of the problems presented by the proposed options was the assumption that they were "black and white options." He proposed that the Commission undertake a "quick and dirty clean-up" of the SHP chapters followed by a thorough review. In his view, the proposed options had merit. He stressed that his proposed solution would occur contemporaneously. The Commission should commit to a full revision of the SHP and achieve that goal within four or five years. Mr. Rosen also proposed that the Commission and staff create an implementation plan for his proposed solution.

Dr. Cowdry expressed deep concern about several constraints. The Commission's proposed budget, recently submitted for FY 07, is nearly $10 million. The statutory cap will be reached by next year (in the FY 08 budget cycle). Staffing PINs continue to be frozen by the Department of Health and Mental Hygiene and management positions continue to be frozen by the legislature. He emphasized that the Commission's finite resources will continue and that this was one of the reasons staff sought to find ways to prioritize and streamline the planning and CON process.

Dr. Cowdry suggested that there are several ways to manage the workload and one of them is to determine what facilities and services no longer need to be subject to CON; a second way is to determine if there are standards that are no longer necessary and are not determined to be top or middle tier priority issues. Dr. Cowdry proposed that, as there is agreement between payer and provider representatives, staff should work with a small group of representatives on revisions to the State Health Plan acute care standards used in CON review. Following additional discussion, Chairman Nicolay asked staff to draft a recommendation for updating the State Health Plan for Task Force consideration. Frank Pommett, Jr. volunteered to be a member of the proposed subgroup. Chairman Nicolay thanked Mr. Pommett and asked other Task Force members to volunteer. Mr. Kane suggested that subgroups be organized on a SHP chapter basis.

Chairman Nicolay announced the next topic for consideration.

- **State Health Plan Issues: Licensure of Total Acute Care Hospital Beds and Projecting MSGA Bed Need**

Commission staff member Paul Parker presented a description of the methodology used for arriving at an acute care hospital's annual number of licensed beds and for the projection of bed need. The briefing memo to the Task Force described the licensure process and the bed need projection methodology in detail. Mr. Parker explained that staff calculates the total acute care hospital capacity based on hospitals' patient census, as required by the 140% rule in the Commission's statute, which was implemented beginning in calendar year 2001. The calculation is based upon hospitals' data on total physical bed capacity, which is reported to the Commission. Commission staff sends notification of the hospital's licensed capacity each year. Hospitals are required to designate the number of beds for each acute care service. The resulting licensed bed capacity serves as the single, official source of acute care hospital bed inventory for the state.

Mr. Parker noted that the licensure figure is dynamic—changing from year to year pursuant to the hospital's patient census. He used Greater Baltimore Medical Center as an example of licensure calculations based upon DHMH records and the hospital's self-reported data in order to illustrate his explanation.

Mr. Parker explained that as a result of implementing the 140% rule's new methodology in 2001, there was a drop from 12,300 to 9,500 licensed acute care hospital beds, as reflected in the table below. The number of licensed acute inpatient beds has increased from 10,321 last year to 10,323 for the upcoming year (fiscal year 2006). Licensed beds have not changed materially statewide because the average daily census has not changed significantly.

LICENSING ACUTE CARE HOSPITAL BEDS IN MARYLAND

Maryland

	WM	MC	SM	CM	ES	MD
2000:	1,011	1,512	1,625	7,314	866	**12,328**
2001:	784	1,294	1,077	5,714	693	**9,562**
2002:	761	1,302	1,082	5,919	727	**9,791**
2003:	766	1,299	1,143	6,052	734	**9,994**

2004:	756	1,305	1,153	6,129	723	**10,066**
2005:	782	1,338	1,190	6,258	753	**10,321**
2006:	779	1,298	1,155	6,328	763	**10,323**

He described the calculations that the 2010 forecast is based upon, which utilizes an average daily census (ADC) range and an assumption of 80% of average annual occupancy, in order to identify net bed need (as set forth in the table below.) The Commission adopted the bed need methodology in calendar year 2004 for MSGA beds.

PROJECTING THE NEED FOR MSGA BEDS IN MARYLAND

MHCC Occupancy Rate Scale for MSGA Beds

ADC	Avg. Ann. Occupancy Rate
0-49	70% (143% rule)
50-99	75% (133% rule)
100-299	80% (125% rule)
300+	83% (120% rule)

Mr. Parker emphasized that the calculation does not apply to all licensed beds, for instance, there is no bed need methodology for obstetric beds. He also noted that, for psychiatric beds, the dramatic decrease in average length of stay (ALOS) would be included in the methodology proposed in the revised SHP chapter.

Mr. Parker said that elimination of the 140% rule would require a statutory change. Currently, a hospital whose physical capacity is lower than its licensed capacity may expand its licensed capacity without meeting the bed need standard; however, other CON regulatory requirements remain in effect, such as the capital threshold.

In response to Task Force members concerns regarding actual physical capacity, surge capacity, and "expansion capacity" when larger, single hospital rooms are configured, Mr. Parker noted that many hospitals have been constructing a larger number of private rooms that are not large enough to permit a later conversion to semi-private rooms. Mr. Rosen suggested that a hospital's physical capacity is irrelevant. Ms. Cody asked why the Commission would be concerned with a hospital's actual capacity when it has demonstrated financial viability for proposed expansion projects. Ms. Barclay replied that a potential danger would be that hospitals would build capacity in excess of what will be used. Mr. Rosen asked why the Commission does not capture trends in a geographic area, such as the baby-boom generation resulting in a growing population of aging patients; dynamic tertiary care, and the decline of managed care factors. Ms. Barclay replied that staff conducts such analysis in updating bed need projections and that results of analysis have revealed trends similar to Mr. Rosen's description; therefore, there is no debate regarding Maryland's need for greater acute care capacity. She also clarified, in response to Dr. Blumberg's concern regarding hospital's actual capacity, that the Commission's calculations are based upon each hospital's self-reported data on physical capacity.

Mr. Tranter observed that the issue of proposed hospital projects based on a 2010 projection of need ties into the issue of "shell space." In his view, hospitals should build shell space now for projected utilization beyond calendar year 2010 and that the pledge not to increase rates is an important

factor in planning. He added that if a hospital builds "shell space," then it does not logically follow that utilization would be equal to its physical capacity. Dr. Cohen expressed concern about hospitals' maximum need, asserted that the Commission must use a correct definition of "efficiency," and emphasized that CareFirst has supported hospital project applications for conversion to private rooms because, while there is greater expense per bed, "there are cost savings in other areas related to improved quality, such as lower hospital infection rates, which drive lower lengths of stay, which drive lower utilization rates, and there is the ability to have higher occupancy rates…that is all part of the system that drives a reasonable expenditure for capital." Mr. Suldan suggested that changing the Commission's "shell space" policy would provide an immediate benefit to many hospitals and, in the long run, would save money for the system. He suggested that the shell space policy is not set forth in either the Commission's statute, or regulations, and should be eliminated.

Chairman Nicolay presented the following options for consideration:

- Eliminate 140% Rule for Licensing Beds
- Adopt the 71.4% Average Annual Occupancy Rate Assumption Implied by the 140% Rule as the Occupancy Rate Standard Used in Bed Need Projection
- Eliminate CON Regulation of Expansion of Hospital Bed Capacity
- Adopt the Occupancy Rate Scale Used in the State Health Plan as the Implied Average Annual Occupancy Rate in Hospital

Chairman Nicolay suggested that one of the Task Force members make a proposal regarding the options. Dr. Cohen offered a general observation that the Commission should determine appropriate occupancy rates for hospitals and apply them through the SHP, rather than codification of those rates by legislative action. He recommended that the Task Force consider a proposal to recommend that the legislature eliminate the 140% rule and set licensed beds as determined by SHP methodologies. Dr. Cowdry observed that the 140% rule was not the pivotal question. The crucial question was whether the 140% rule gives a hospital, by right, the ability to expand bed capacity without a need determination. In his view, none of the proposed options captured the crux of Dr. Cohen's concerns, i.e., equity among different providers and fidelity to the concept of need based regulation.

Dr. Cohen agreed with Dr. Cowdry's assessment. Ms. Barclay clarified that the term "licensed capacity" means the number of beds a hospital is authorized to operate. Mr. Tranter pointed out that it is implicit in the current licensure law. Dr. Cohen reiterated his recommendation to eliminate the 140% rule, and added a recommendation that the ability to have the number of beds for which a hospital is licensed, unless that number is based on a determination of need, also be eliminated. Ms. Brown argued that no hospital builds, or plans to build, to 140% of occupancy. In her opinion, no hospital believes that it is achieving maximum efficiency at 71% of occupancy. The 140% rule provides the flexibility that hospitals need to expand capacity, as necessary, in response to growing demand. Bed capacity and bed need projections, with new standards projecting need as of 2004, have been established in statute and regulation.

Mr. Parker pointed out that pursuant to the 140% rule, a hospital's license changes each year. For all forty-seven acute care general hospitals, the licensure rule is roughly congruent with the bed

need projection. Following discussion among the Task Force members, Mr. Pommett pointed out that as a result of the 140% rule, demonstrating consistent, sustained growth permits flexibility for acute care hospitals.

Dr. Wilson noted that he would be reluctant to recommend limits to flexibility, citing, for example, that Peninsula Regional Medical Center's (PRMC's) licensed bed capacity was increased by twenty-three beds last year (due to the 140% rule) and in light of the recent unprecedented regional growth , PRMC has reached maximum capacity. Dr. Wilson was concerned that if flexibility were eliminated, then PRMC would exceed capacity prior to completion of its proposed expansion project.

Mr. Rosen said that the licensing rules should drive the Commission's methodology. In response to Chairman Nicolay's request, Mr. Rosen proposed that the Commission use a need projection that is consistent with the 140% rule, as mandated by the legislature. Dr. Cohen argued that the 140% rule was adopted in order to eliminate paper beds. In his opinion, using the rule as a standard in the SHP would be result in a policy that would be inconsistent with the legislative intent when the rule was adopted. He proposed that the Task Force adopt the fourth option under consideration. Mr. Tranter and Mr. Rosen disagreed with Dr. Cohen's analysis.

Mr. Rosen again reiterated that the Commission should be establishing policies that are consistent with the statutes enacted by the legislature. He proposed that the option recommended by the Task Force should be that the Commission's rule remain the same as the licensure rule. He also suggested that if the Task Force wanted to recommend a change to the licensing rule, then the issue should be delegated back to the Commission for consideration. In the interim, he indicated that the policy must be that the Commission conforms until there is change to that which it conforming to. Mr. Tranter agreed with Mr. Rosen.

Mr. Rosen made a motion that the Commission adopt a need projection that is consistent with the current licensing criteria for all medical services, for all licensed beds. He clarified, in response to questions from Mr. Tranter and from Ms. Barclay, that he was not addressing the allocation of beds. Mr. Rosen restated his motion: "For projected bed need, the Commission should be using the licensing formula for beds in the State of Maryland, whatever it is at a current period of time." Following discussion, the motion died, as there was no second.

Dr. Cohen made a motion that the Task Force recommend option number four to adopt the occupancy rate scale used in the SHP as the implied average annual occupancy rate for hospital licensure, which would require legislative change. Chairman Nicolay observed that Dr. Cohen's motion died, as there was no second.

Dr. Blumberg made a motion that the Task Force adopt option two, which was seconded by Dr. Hussein. Ms. Stefanides said that the motions proposed thus far had not addressed the issue of the policy application for allocation of licensed acute care hospital beds, as Ms. Barclay had discussed. Following further discussion, Chairman Nicolay called for a vote on the motion. Voting in favor were: Blumberg, Chester, Hussein, Pinkner, Pommett, Rosen, Suldan, Stefanides, Tranter, and Wilson. Dr. Cohen voted against the motion, and the following Task Force members abstained: Bonde, Brown, Cody, Kane, Meilman, and Weglein.

Dr. Cohen made a motion that the Task Force recommend the elimination of the 140% rule, which was seconded by Dr. Blumberg. Voting in favor were: Blumberg, Cohen, and Kane. Opposed

were: Brown, Pinkner, Pommett, Stefanides, Suldan, Tranter, and Wilson. The following Task Force members abstained: Bonde, Chester, Cody, Hussein, Meilman, Rosen, and Weglein.

Mr. Suldan made a motion that the existing policy of not permitting hospitals to construct shell space be eliminated and that hospitals be permitted to build shell space, so long as they do not seek to include the cost of the vacant space in their rates while it is vacant. Dr. Wilson seconded Mr. Suldan's motion. Dr. Meilman pointed out that there is a probable inability of our current hospital system to absorb any type of catastrophic event with survivors, such as an anthrax attack or another event similar to September 11th in the Washington area. When he was in medical school, approximately half of the hospitals' patients could have been asked to go home at any time because they were receiving elective care. Presently, most hospital patients are too sick to move. The Task Force and Commission should consider hospital capacity to deal with this issue. Susan Panek, the Commission's Chief of Certificate of Need, noted that Maryland Institute for Emergency Medical Services Systems (MIEMSS) has a work group considering the issue.

Mr. Kane inquired whether Mr. Suldan's motion included shell space in nursing homes, which also had surge capacity issues. At Chairman Nicolay's request, Mr. Suldan clarified that his motion applied to only to hospitals. Chairman Nicolay called the question. The motion was unanimously approved.

Mr. Kane moved that nursing homes be able to build shell space. The motion was seconded by Dr. Cohen. Task Force members Cohen, Kane, and Wilson voted in favor of the motion. Abstaining were: Blumberg, Bonde, Chester, Cody, Pommett, Rosen, Stefanides, and Tranter.

- **Follow-up Items: Guiding Principles**

Chairman Nicolay announced that a Working Paper, *Guiding Principles for the Maryland Certificate of Need Program*, had been revised and provided to the members present for purposes of discussion. He thanked the Task Force members for sharing their views on the subject, which were reflected in the first half of the document. Dr. Cowdry commented that the second half of the document articulated principles that had been triggered by the stimulus provided in comments received about the role of competition and the interesting tension between the Commission's work and market forces in the health care market. He emphasized that the draft Working Paper was not meant to be a statement of policy. Instead, it was a "thought piece" analogous to some of the written comments received by the Commission. In Dr. Cowdry's view, it was quite possible that the majority of Task Force members' written responses to the draft would endorse the short list of general principles; however, it would be of great interest to understand the Task Force members' perspectives on his comments as the Commission goes through a strategic planning process for the next five to ten years, e.g., what the performance reporting system should be like and to what extent that system should interact with health care technology capabilities in ten year's time; and what should the Certificate of Need program be like in an environment where there is better information and, at least in some areas, better opportunities "for the market to actually operate like a market."

Chairman Nicolay added that the draft Working Paper represents the mission statement for the deliberations and considerations of the CON program by the Task Force and the Commission. Due to the absence of some of the members, he directed that the staff email the document following the meeting.

- **Follow-up Items: Completeness Review and Re-Docketing**

Chairman Nicolay introduced proposed restructuring of the review process:

- Require two conferences in the review of any CON application.
  - Application Review Conference
  - Project Status Conference
- Allow for changes in a project that bring it in closer conformance with the staff's or Reviewer's analysis, without penalizing such changes by adding more process or time to the review.

Dr. Wilson thought that the restructuring would result in faster docketing of applications; however, he asked if staff would continue to pose questions to applicants after an application has been deemed complete. Mr. Parker stated that the proposed application review conference would provide an opportunity for better communication and efficient responses for the applicant, Commission staff, and any appointed reviewer. Mr. Tranter suggested that the Commission retain the current completeness review rules and return to the "old process" that limited the number of times an application was reviewed for completeness. Ms. Wideman stated that the purpose of completeness questions was for staff to get sufficient information to review an application. Ms. Brown noted that, in Johns Hopkins recent major application, completeness review was not a problem because Hopkins knew the information staff needed and supplied it. Mr. Rosen suggested that the critical question relates to the timeframe within the context of when an application is deemed complete. Chairman Nicolay replied

that the proposal did not include a change to the timeframe regulations. Dr. Blumberg made a motion that the Task Force recommend restructuring of the review process as delineated in the briefing paper, which was seconded by Dr. Chester. Task Force members Bonde, Blumberg, Brown, Chester, Cohen, Kane, Meilman, Pinkner, Pommett, Rosen, Suldan, Tranter, and Weglein voted in favor of the motion; Stefanides and Wilson abstained from voting.

- **Follow-up Items: Interested Parties**

    - Designation of Third Party Payers
    - Definition of Adversely Affected

Chairman Nicolay emphasized the importance of taking a balanced approach in the designation of interested parties. In response to a question from Dr. Blumberg regarding rights to make comments in support of a proposed application, in consideration of the public process described by Commissioner Ginsburg at an earlier meeting, Ms. Wideman described the current standards for designation of interested parties, as provided in regulation. Following discussion, Mr. Tranter made a motion that the Task Force recommend that the Commission leave the existing rules for interested parties, third party payers, and the definition of adversely affected exactly as they are. His motion was seconded by Ms. Stefanides. Task Force members Bonde, Brown, Chester, Kane, Meilman, Pinkner, Pommett, Rosen, Suldan, Tranter, Weglein, and Wilson voted in favor of the motion; Blumberg and Cohen voted against the motion, and there were no abstentions.

- **Follow-up Items: Ambulatory Surgery Services**

Chairman Nicolay announced that comment received from Dr. Pinkner and Deron A. Johnson on behalf of the Maryland Ambulatory Surgical Association was distributed to the members of the Task Force for later consideration.

4. <u>Other Business</u>

- **Updated Meeting Schedule**

Chairman Nicolay pointed out the addition of a Task Force meeting to be held on Thursday, September 22, 2005 at 1:00 p.m.

5. <u>Adjournment</u>

Chairman Nicolay announced that the next meeting would be held on Thursday, September 8, 2005 at 1:00 p.m., and upon a motion by Dr. Blumberg, and seconded by Ms. Brown, adjourned the meeting at 4:28 p.m